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DIVERTICULITIS AND CANCER OF THE COLON*

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THE SURGEON is used to difficult decisions and usually makes them correctly after carefully weighing the evidence. However, he is confronted by a real dilemma which taxes his best judgment when the differential diagnosis lies between complicated diverticulitis and cancer. The usual uncomplicated diverticulitis with spasm is not hard to recognize. The usual cancer of the large intestine is equally easy to estimate.

The complications of diverticulitis consist of perforation with consequent abscess or peritonitis; the formation of adhesions about the leak, causing matting together of adjacent structures like omentum, small intestine, and bladder; the fixation of the area to the parietes; the development of bizarre sinuses and fistulae; the formation of multiple pus pockets in the wall of the sigmoid leading to fibrosis with narrowing to partial and even to complete obstruction of the large bowel; and the formation of a firm mass of tissue difficult to differentiate grossly from carcinoma.

In diverticulitis with perforation the patient is more ill than in the usual diverticulitis. His pain is more severe. It may radiate more widely toward the back, rectum, thigh, hip or penis. It is accompanied by nausea, vomiting and distention in most instances. The temperature tends to be more elevated and the pulse goes up with it. The white blood count rises to a higher range except in some of the very aged. Spasm is usual and a tender mass can be felt by abdominal, rectal or pelvic examination in most cases. Perforation into the general peritoneum is unusual fortunately, though with the antibiotics now available it would not be as serious as formerly. The vast majority of patients form a well localized abscess which may cause other symptoms such as bladder irritation, dysuria, increasing constipation or diarrhea, loss of weight, loss of strength and weakness.

Drainage of the abscess may lead to a fistula from the bowel to the skin. Failure to drain the abscess may allow it to burrow and to open by itself into another hollow viscus forming such fistulas between the bowel and urinary bladder, between the large and small intestine; into the urethra; rectum or vagina. Multiple openings may be present.

In case of repeated attacks of inflammation in the diverticula there may result thickening and scarring of the large bowel wall. This leads to a loss of elasticity, and narrowing of the lumen, going ultimately into partial or complete obstruction. This occurs with enough regularity to be recognized as one of the causes for large bowel obstruction.

The symptoms given by cancer of the colon have been stressed for a number of years so that they are well-known to members of the profession. The difference between the cancers on the right side of the colon and those on the left have been emphasized. The laboratory tests for blood in the stools; the importance of rectal examination; the value of sigmoidoscopic observation and biopsy; and the study of barium enemas with contrast air injections for accurate estimation of the state of the colon wall and lining, — have all been pointed out as necessary in the diagnosis of colonic cancer.

Perhaps it is not as well known that in some cases the growth extends through the colonic wall; and then, that an abscess forms; that occasionally also the omentum, small intestine and bladder become involved in such a case by adhering to the inflamed area; that the lesion becomes adherent to the parietes; that rarely there are fistulas between the colon, bladder and small intestines; that large bowel obstruction may be partial or complete; and finally, that the inflamed mass may cause fever, leucocytosis and a tender mass almost impossible to differentiate from complicated diverticulitis.

Cases of cancer with the above complications present problems in diagnosis to the physician, to the

continued on next page

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gynecologist, to the urologist, to the radiologist, to the pathologist, and to the surgeon. There is rarely complete agreement between them on any individual case. The pathologist, of course, has the final judgment when his microscopic sections are available. But he has been just as puzzled as any of the others when he has the same evidence as they, including the gross specimen.

It used to be taught that the presence of blood in the stools was an argument in favor of cancer as this event was of rare occurrence in diverticulitis. More recent studies have shown that the presence of blood in the stools is by no means unusual in cases of complicated diverticulitis and even 20% of simple diverticulitis with spasm may show blood at times. The discovery of blood is, however, an important finding. And the attending doctors should regard any such occurrences as indicative of malignancy till proved otherwise.

The physician finds himself responsible for a patient who gives a history of attacks of typical diverticulitis with spasm. Perhaps there have been barium studies in the past with clear demonstration of the diverticula in the sigmoid and the "picket fence" spasm above it. But on this occasion there is blood in the stools on repeated examinations. If he takes the initiative and treats his patient as he would the usual diverticulitis, he must be prepared to reverse himself if conditions indicate that he is not getting the proper prompt response. Continuation in the conservative course may jeopardize his patient's chances for surgical relief.

The gynecologist not infrequently sees a patient with a mass which is one with the left tube and ovary and may even push the uterus over. It may be tender and bulge in the cul de sac. The intestinal symptoms are minimal or minimized, so that barium enema studies are not even considered. The diagnosis is usually an ovarian tumor or cyst or it may be pelvic inflammation. When the exploration has been carried out and the sigmoid is found to be the offender, the surprise is great. In all suspected left-sided tumors of the tube and ovary, a simple fluoroscopic barium enema examination might save a lot of embarrassment later.

The urologist may be caught by these complicated diverticulitis cases. He is usually aware of the fistulas from the bowel to the bladder and gets the proper studies or consultations as indicated. When the diverticulum perforates into the extraperitoneal space near the bladder, gas crackles may develop in the area. He then thinks that he is dealing with an extravasation from the bladder or urethra.

The radiologist has a really difficult diagnosis to make when there is obstruction, partial or complete, at the recto-sigmoid. Often, the bowel is irritable and the patient cannot retain the barium enema. The radiologist is unable to get barium beyond the recto-sigmoid. It pinches off as a complete block. Or, he may get a little trickle by which gives a very confusing outline to the sigmoid lumen. He may not be able to see any diverticula at all; or he may interpret flecks of barium trapped in an ulcerated area as diverticula. Under these conditions the wise radiologist hedges. He says that he is unable to make a differential diagnosis between cancer and an inflammatory mass in these cases. He advises "repeat examination in a week or after medication." If blood has been demonstrated in the stools he says usually "that the evidence is in favor of carcinoma although inflammation cannot be ruled out."

When the pathologist is called upon to give his opinion of a gross specimen of complicated diverticulitis he is as uncertain as the surgeon. If he can open the specimen and see that the mucosa is intact, it is usually safe to call the lesion benign. But, not always. Some infiltrating carcinomas are deceptive and show no demonstrable breaks in the mucosa. When the surgeon has to leave the gross specimen in situ the pathologist judges by the appearance of inflammation in the area. Often a biopsy is taken from the nearby structures which seems to be surely neoplastic, only to have "inflammatory tissue" or "hyperplasia" returned from the frozen section study. The pathologist, as in every other situation, has the final word.

The real burden of responsibility falls on the surgeon. The medical man and the radiologist do not hesitate to press for an answer in a doubtful case. They urge the surgeon to explore and to establish the diagnosis. If the surgeon feels a little hesitant and believes that the patient should be treated conservatively they agree but feel relieved that the burden has been shifted. Before the antibiotic era, exploration was a considerable hazard in these complicated cases. The infection could be stirred up and generalized by the trauma of resection or by simple palpation. The anastomosis in an infected zone might fail to unite properly with a resulting necrosis and a new abscess or a fistula. But we can now disregard these dangers to a large extent by proper selection of the correct antibiotic before and after the operation. Every patient who has a mass and who has bleeding from the bowel is a proper candidate for exploration. Even with the lesion in his hand the surgeon has only a 50-50 chance to make the right diagnosis. In every case it is safer to proceed as if the diagnosis is surely cancer. And to be pleasantly surprised when it turns out to be inflammatory only.

The coexistence of diverticulosis or diverticulitis and cancer in the sigmoid colon is considered quite rare. Oren reported on two such cases in 102 cases of diverticulosis. He quoted the other writers noted below. Fallon had only 3 cancers in 625 cases of diverticulitis and in 1800 cases of diverticulosis.

In 1600 operations for cancer of the colon only 19 had diverticula in the same area. Rankin and Brown found cancer in only 4 of 227 cases of diverticulitis and in all their cancer operations diverticula were present in only 4. Tom Jones reported the two lesions together in 3 of 300 cases. Arnheim reviewed the 10 year period of diverticulitis cases admitted to the Mount Sinai Hospital. There were 35 cases. In only one case was there an associated carcinoma.

There is no evidence that diverticulitis is a precursor to cancer. The fact that the two lesions may coexist is easily accounted for. According to Karsner diverticulosis of the large intestine is present in 25%-30% of all adults. The sigmoid is the segment of predilection for this condition. It is generally conceded that 25% of all the colon cancers occur in the sigmoid. The probability of the two conditions existing together is therefore to be expected.

There have been 13 cases of coexistence of the two lesions in the sigmoid in the University of Rochester hospitals. There have been 10 additional cases of carcinoma elsewhere in the colon with diverticulosis or diverticulitis in the sigmoid. When these cancers are in the rectum or at the recto-sigmoid their diagnosis is usually possible. The cancers at the cecum, transverse colon and at the flexures may or may not be so easily picked up especially if there is marked spasm in the sigmoid above the diverticula or an abscess which further complicates the picture. These complications may completely mask the cancer for a considerable period.

There have been 17 additional cases of partial or complete obstruction at the sigmoid or recto-sigmoid junction. Many of these have had other complications such as abscess and fistula. The diagnosis in this group has been exceedingly difficult and has tested the resources of all concerned. These 17 cases have been considered to be complicated diverticulitis as no cancer has been demonstrated in any of them. They have all shown diverticula by x-ray examination. Abscesses have been drained in quite a number and their subsequent course has been proof of infection alone.

Tissue which appears likely to help establish the diagnosis should be secured for microscopic examination if possible. It is well to remember that a negative report for carcinoma, however, does not mean that there is surely none present. It may simply represent an unfortunate selection of tissue. Sometimes as many as 3 or 4 biopsies have failed to show cancer and yet it was present deeply imbedded in the inflammatory mass. The lymph nodes removed for diagnostic purposes have usually turned out to be hyperplastic.

The history of blood in the stools or tarry stools always calls for the most careful scrutiny to determine its source. In the 13 cases which proved to be cancer, blood in the stools was demonstrated in 10 of them. The other 3 cases gave no history of it and it could not be demonstrated by stool examination. In the 17 cases which turned out to be diverticulitis with complications blood was found in the stools only 6 times. The failure to get a history of bloody stools and the inability to prove it by clinical test would make one lean more toward the diagnosis of an inflammatory lesion.

In no other respects were the history or physical examinations of differential diagnostic value. The patients all showed evidence of a severe disease of some kind. The proof rested finally on microscopic section. In some doubtful cases the ultimate diagnosis was not proved. These have not been included in this study. Other cases which were thought to be a combination of cancer and diverticulitis have turned out to be cancer alone. These have been set aside also.

Proctoscopic or sigmoidoscopic examination in both groups of cases is indicated. It may serve to define the cause for bleeding in some cases. Hemorrhoids, fissures or polyps low in the rectum will be recognized. Occasionally, a biopsy can be secured which will allow the diagnosis of cancer. The presence of pus and blood is seen also but this may mean infection only and should not be stressed as a diagnostic point.

Many patients with marked spasm or with obstruction cannot retain the barium and the barium enema study fails because of this. In some instances it has been possible to make a diagnosis of cancer by putting barium into the distal loop of a colostomy and having it outline the lesion in the sigmoid. The x-ray differential diagnosis between cancer and diverticulitis is based on the following points. In diverticulitis there is associated picket-fence spasm above the area often for a considerable distance; there is absence of distention of the large bowel above the diverticula; there is a relatively longer segment of intestine involved; and diverticula can be demonstrated, often retaining barium in them a long time after examination. The area is usually tender on palpation. The bowel is more distensible. After a period of medical treatment the improvement may be marked giving an entirely different picture when the spasm has relaxed. In carcinoma there is a nodular filling defect or a napkin-ring construction about the bowel. It is usually not sensitive on palpation. It is rigid and non-distensible; it is firm but not fixed. In complicated cases of cancer or diverticulitis all these criteria fall down and merge into each other. This is one of the reasons for the difficulty in diagnosis.

The treatment should be pushed in all doubtful cases. It is fair to give a reasonable medical trial

continued on page 353

INDUSTRIAL MEDICINE AND THE PRIVATE PRACTITIONER*

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IT WAS with real enthusiasm that I accepted the invitation to speak to this group of physicians on some of the broader aspects of industrial medicine, emphasizing its objectives and procedures and the essential role played by the Private Practitioner of Medicine.

As you will gather from the title, I will not concern myself with details of diagnosis and treatment.

It is a rash individual who appears before a group of physicians at a professional meeting and expects to hold their interest with a subject non-clinical in nature. I am, however, convinced that what I have to say has a practical application for each of you.

In order that you may have a proper background for my remarks, I will list briefly the objectives of a modern progressive industrial medical program as follows:

1. To select personnel physically able to do the work expected of them with no hazard to their health and safety or to the health and safety of their fellow employees.
2. To provide prompt medical care for industrial accidents and injuries.
3. To assist in the maintenance of a sanitary working environment free from industrial health hazards.
4. To apply preventive medicine techniques including health education and health counseling.
5. To provide sufficient medical care for non-industrial illness, including medication to render the employee relief and comfort, if it is decided that he should stay on the job.
6. To advise and assist the employee in obtaining prompt medical care for non-industrial illness or accident from his personal physician when such is indicated.
7. To work with Management in every practical manner to insure minimal absentee rates and minimal duration of absenteeism from illness and accidents.
8. To cooperate with, but not to replace, the private practitioner of medicine and the official and non-official health agencies of the community.
9. To comply with the Workmen's Compensation provisions and industrial hygiene codes of the respective states.
10. To work closely with those charged with safety practices.
11. To cooperate with Medical Schools, Schools of Public Health, and Schools of Nursing in their educational and training programs in the field of Industrial Medicine.
12. To carry out pertinent research.
13. To maintain the highest professional standards in the attainment of the foregoing objectives.

It is my belief, for purposes of this discussion, that the term "industrial medicine" can be somewhat of a misnomer. I say this inasmuch as it implies a specialty, distinct and separate from private practice. I do not say that specialized interest, training and knowledge are not essential for the physicians in industry. I do mean, however, that there would be no industrial medicine in this country without the private practitioner. He has made it the effective weapon it is today, and has developed it along with his practice. Industrial medicine is closely woven into the general pattern of medical practice in this country. Actually thousands of physicians have part-time industrial medical appointments.

There is a definite tendency and a real need for industry to develop full time medical departments. The bulk of the problem will, however, continue to fall upon the shoulders of the private practitioner. Even in those industries where medical departments have been established, many of the services are rendered on a part-time basis. It is well recognized too that the major problem in industrial health today is the problem of the small plant where no medical services whatever are provided. This deficiency will probably be filled by part-time physicians, although full time service by one physician to a group of small plants is a promising and progressive procedure.

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Even in those industries where you find a well-equipped and well-staffed medical department, with a good program, there are very few, if any, which go beyond the diagnosis of conditions in the ambulatory employee and health counseling. Referrals are then made to the personal physician. I do not have reference here to the industrial accident case, which may account for but a small proportion of industrial clinic visits. This proportion of course varies with the nature of the industry. The heavier the industry, as a rule, the higher the proportion of visits for industrial accidents of total clinic visits.

Importance of Industrial Programs

Why do industries have medical programs? The reason is obvious: to insure a healthy, safe, happy, efficient employee population *per se* and in the interest of economy. Several states have already adopted laws which make it mandatory upon management to provide certain benefits for the individual who is ill for non-industrial reasons. Most absenteeism in industry is due to non-industrial personal health problems. It is, therefore, important for management to invest in preventive medicine. In those industries where the industrial accident load is not heavy most of the clinic visits are for personal health reasons. In many such cases, however, the employee would not have consulted his private physician. This does not mean that the visits were not justified. Nor does it mean that such visits are not a challenge to the industrial physician and nurse. The employee had some complaint, however vague, some problem, and took it to the physician or nurse for guidance at a stage when he probably would not have sought advice were the services not readily and freely available. The industrial physician and nurse must be constantly aware of the opportunity this presents to sense trouble at that very early stage, so favorable for effective action.

All procedures in the industrial clinic are carried out at a high professional level and in a confidential manner. The union, employees, management and medical profession must be completely informed as to the objectives and program of the medical department. They must realize that industrial medical departments are more than first-aid stations.

It is well appreciated by all of us that, equipped though we are with miracle drugs and miracle skills, an important cause of death and disability continues to be the lag between the development of symptoms and the institution of treatment. We in industrial medicine are in a position to do something about this very tangible problem.

The Role of the Physician

I will now discuss in some detail certain aspects of an industrial medical program emphasizing the important role played by the private practitioner. By this designation "private practitioner" I include both the general practitioner and the specialist.

The first duty of an industrial medical service and, indeed, the duty which resulted in its creation, is the provision of medical care for industrial accidents. This problem varies widely in accordance with State laws, personnel, and equipment available. Some of our larger heavy industrial plants have full-time medical departments and well-equipped hospitals on the premises. They carry out complete diagnosis and treatment. Frequently, however, industry provides the initial care for a major accident and the case is then referred to an outside source for further diagnosis and treatment.

I would like to digress at this point to emphasize that the industrial physician who approaches each problem with interest and imagination never finds his work lacking in stimulation. It is occasionally said that the industrial physician who must refer many of his problems, will invariably lose his interest and skill. I do not concur in this belief.

Certain states have provisions in their Workmen's Compensation Law which provides that even though physicians are available on the premises for first aid and continued treatment, the employee has the right of free choice of outside physicians. This further emphasizes the close association, in fact the inseparability, of industrial medicine from the private practice of medicine.

Another facet of the industrial medical program is the provision of pre-placement physical examinations. Certainly industry has the privilege and even the duty of ascertaining before employment that the individual is actually capable of doing well and safely the job for which he may be hired. The pre-placement physical examination is *not* undertaken to eliminate from employment all but the physically perfect. In many cases these pre-placement examinations are accomplished by full or part-time physicians on the premises, but in many instances they are done on a fee basis on the outside by outside physicians.

It is necessary when doing these examinations to keep in mind the objective of the examination, namely, the selection of a safe, healthy efficient employee. The physician should know and keep in mind the physical demands of the job. If it is a travelling salesman position, for example, it should be remembered that a salesman may spend long, weary hours driving under all road conditions and may or may not be expected to carry heavy loads.

In most industries there is a broad classification of potential employees into one of four basic groups:

Group 1 Those physically acceptable immediately for all types of employment.

Group 2 Those physically acceptable but only for certain types of employment.

continued on next page

Group 3 Those rejected pending correction of defects.

Group 4 Those rejected and in which no further action is indicated.

An alert, progressive Medical Department keeps its Group 4 (absolute rejections) percentage to a minimum. Industry should provide opportunity for the disabled to earn a livelihood, and the disabled frequently make excellent employees. There is a distinct contribution in a pre-placement examination if one bears in mind that those with remediable defects in Groups 2 and 3, of whom there are many, often thank this procedure for resultant definite improvement in their physical well-being.

Pre-Placement Examinations

The pre-placement examination should not be a routine asking of questions and a cursory examination. It is the forerunner of and typifies what is being developed today outside of industry; I have reference to the periodic health examination. In most cases a complete physical examination, including history, is given, taking approximately 30-45 minutes. Most industries require chest x-rays and blood tests. If by any chance you do pre-placement work for an industry, make it a real, worthwhile procedure of value alike to management and employee, and not a mere matter of form.

Individuals classified as Group 2 or 3 are, of course, referred to their personal physician for correction of defects at their own expense. Your response should be and most frequently is cooperative and helpful.

Such a response is possible, however, only if the objectives and scope of the examination are sincerely understood and appreciated. In this connection it is revealing how many individuals have no personal physician, or, if they have one, have not visited him for years. The practice of pre-placement physical examinations in industry often stimulates the selection and utilization of a private physician on the part of the employee.

Only recently, we had occasion to do a pre-placement physical on a girl with unusual secretarial training and experience. She was applying for a position of considerable importance. Several weeks had been consumed in finding this person. It would also require several months on-the-job training to bring out her top performance.

Her immediate past health history was negative, as was her absentee record with her previous employer. In other words, failure to have a pre-placement physical would have resulted in her rheumatic heart condition being overlooked. She had rheumatic fever at 14 and had not been to a physician since that time. Upon physical examination she showed definite evidence of an enlarged heart and cardiac arhythmia, confirmed by x-ray, fluoroscopy and electrocardiography.

A cardiac consultant advised that without preventive therapy she would probably decompensate within one year, but that on a proper regime she would be a good risk.

The young lady was employed provided she placed herself under the care of her personal physician.

Thus a distinct service was done in the pre-placement physical both for management and the employee. I will add what many of you might suspect, selling the young lady on the idea was a most difficult and trying experience.

Periodic Health Examinations

Many industrial medical programs, and the number is increasing, provide for periodic health examinations for entire groups or for certain selected groups. These periodic health examinations are in some instances carried out on a contract basis by outside physicians. In other cases they are performed by full time personnel. In most cases they include chest plate and electrocardiograph, although in many instances history and physical alone are provided. Participation usually is voluntary and results are strictly confidential. As a rule no treatment is provided. Copies of the findings may usually be sent to the individual's personal physician upon request of the employee. Here again the closest possible cooperation between the private practitioner and the medical department of the industry is absolutely essential. The private practitioner to whom these cases may be referred for more definitive examination, or for correction of defects, must have a keen and complete appreciation of the periodic physical examination. He must not have the attitude occasionally found that such are a waste of time.

The problem of periodic physical examinations can become so tremendous that many industries, in order to do a more complete and efficient examination, limit these services to executive groups, to those exposed to possible industrial hazards, individuals with poor accident records and those with poor health and efficiency records.

The usual policy followed in cases of clinic visits for personal health reasons is to provide medication to make the employee more comfortable, if he is to remain at work, or to suffice in any event until he can see his personal physician.

It cannot be over-emphasized that the industrial medical department in no way attempts to replace the private practitioner of medicine. It supplements his work but it never replaces him. Due care is taken when treatment is given and the person referred to a physician, that the treatment given is not of such a nature as to interfere with subsequent diagnosis. In providing this initial diagnosis and referral to the private practitioner, there can be no doubt that a tremendous opportunity presents itself.

Many of these individuals might have delayed consulting a physician for weeks or months. Here is the closest possible effective relationship between the private practitioner and the physician in industry. The one does not take the place of the other, but makes the other more effective.

It is routine procedure in most industries for individuals who have been out ill for one reason or another to return to work only with the approval of the medical department. In many instances clearance by the personal physician is demanded in illness involving several days' absence. Here again close cooperation between physicians is necessary and should result in minimal absentee rates and duration of absence.

Health Education Lags

The possibilities of health education and health counseling techniques as part of industrial medicine have not been fully developed. It is a rare clinic visit which cannot be used as an entering wedge for good sound health counseling such as you all do in your office. The preparation of articles for the industrial house organ, usually in cooperation with national health education drives, which are almost monthly, can contribute materially to positive employee health.

A most important part of any industrial medical program is the anticipation, recognition, prevention and control of industrial hazards. The physician who is engaged part time in industry must be personally acquainted with every part of the plant and operation which he serves; he must visit all parts of the plant at frequent intervals; he must be familiar with the materials used, with the methods used, with their toxic and hazardous potentialities. He must be informed of and aware of new processes and procedures which might involve hazards not present up to that time.

The private practitioner seeing an employee on the outside must keep in mind the possible industrial implications of any complaint. If indicated, he should communicate with the plant physician concerned for a mutually beneficial exchange of information.

The nurse plays a major role in any industrial medical program. Many industries provide no service other than that offered by a nurse. In many instances where part or full time medical personnel is available, the nurse screens out those employees whom she judges should see the physician. In these decisions she is expected to be capable of independent professional judgment and should be acting in accordance with the written standing orders of a physician supervisor. The physician in industry should take the time to discuss interesting and important cases with his nurse. Only in this way will she be able to provide him and the employee with the necessary and important follow-up service.

Industrial medicine affords a splendid opportunity for medical research. We are dealing with a self-contained group which is, on the average, more amenable to our efforts than the general population. Our files are filled with epidemiological data as to the behavior of disease.

It is my earnest hope that industrial medicine will continue to develop as part of the pattern of the general practice of medicine with emphasis placed on perfection. Development of all possible cooperation between the industrial and the personal physician and complete enjoyment by industry and medicine of the mutual benefits springing from close association in teaching and research, are much to be desired.

DIVERTICULITIS AND CANCER OF THE COLON

concluded from page 349

in the hope of a prompt recovery. The usual medical treatment is employed. Rest, low residue diet, antispasmodics and antibiotics are the customary treatment. Some clinics use local careful irrigations and others avoid them. The fever and leucocytosis should subside within a few days. Tender masses may get smaller and less sensitive. If this does not occur, drainage of abscesses may be indicated. After this has been done recovery should be prompt in diverticulitis cases but if it does not take place more drastic measures must be taken. Surgery should be radical as if for cancer, taking parts of whatever organs or tissues are adherent to the growth and repairing the defects afterwards. These operations are by no means simple. Sometimes two or three loops of small intestine and a portion of the urinary bladder will be involved in the mass. To separate them will be fatal if there is cancer spreading through these tissues. Consequently in some cases tissues will be removed for inflammation only but this is a risk that must be balanced against that of spreading a possible cancer.

THE PROBLEMS OF GENERAL PRACTICE AND THEIR SOLUTIONS*

CHARLES E. MILLARD, M.D.

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OF ALL the manifold problems besetting the medical profession at this time, that of restoring the family physician to a position commensurate with his contribution to society appears to be one of the most pressing. Unless this problem is solved to his advantage, all of medicine will come crashing from its lofty pinnacle. The family physician is the basic unit of the medical system and is the profession's greatest bulwark against socialized medicine.

Sir William Osler said: "The public bases its estimate of the medical profession on its opinion of the family physician, who is the yardstick by which all medical care is measured. By elevating the status and dignity of the family physician, we elevate the status and dignity of American medicine as a whole."

More recently, Dr. Kirkland, Secretary of Advisory Board of Medical Specialties said that the general practitioner is indispensable to the public and is the basic unit of the medical profession, which cannot be denied. As a matter of self interest, if for no other reason, all other groups in the profession should vigorously defend him from exploitation and assist him in securing his rights and proper dignity.

When one considers the fact that approximately 80 percent of the practice of medicine is in the hands of the general practitioner, and that upon his decisions depends the life, health and welfare of such a large majority of our people, his importance is immediately self-evident. It should, therefore, behoove the medical profession to do everything within its power to make these men as competent and as well-trained as is humanly possible.

However, in the past two decades, diametrically the opposite view has become prevalent. As you are all well aware, there has been tremendous emphasis placed on specialization while de-emphasizing general practice. This is clearly demonstrable by the following:

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While our population has increased about 12 percent, our physician population has increased 14 percent. However, because of the large number of our younger men entering the specialist fields, the general practice population has decreased. In 1949 there were approximately 199,775 active practicing physicians in the United States, and of this number 42,000 were specialists, 29,000 Board certified, and 13,000 listed themselves as part time specialists.[1] In 1941 there were a little over 5,000 residencies whereas in 1949 there were over 15,000 residencies.

There are many factors operating to deplete the number of men entering general practice, and chief among these are:

1. The failure of our medical schools and hospitals to provide adequate training facilities for men desirous of entering general practice.
2. The tendency of hospitals to approve for staff appointments only those men certified by the specialty boards. This immediately offers a serious deterrent to our younger men because they have been trained to use all the scientific adjuncts of the modern hospital for diagnosis and treatment. Thus, if he is not going to be able to obtain hospital privileges, there is little inducement for him to enter general practice. If he did enter general practice under these circumstances, he would function solely as a clearing station to refer to the various specialized groups those patients that he cannot treat in his office and home. His position would be analagous to the battalion surgeon in the Army who functioned solely to screen the sick from the non-sick, and all interesting problems were referred to the hospital for treatment. This leads to stagnation.

Of course, it is easy to understand how this situation developed. Hospital authorities are concerned with maintaining the quality of medical care provided in their hospitals. Hospital administrators needed standards to measure the training and ability of the physicians desiring staff privileges. The specialty boards met this need adequately by setting up certain minimum requirements for its membership. This resulted in the present day trend of selecting staff physicians solely on the basis of certification. Hospital authorities cannot be blamed

for using the standards formulated by the medical profession.

National Bodies Act

However, as is so often the case when something becomes a fad, the pendulum has swung too far. The curtailing of hospital privileges by demanding certification, or by simply closing the staff, prevents the competent general practitioner from caring for his patients to the extent of his ability. This is such a manifest injustice that cognizance has been taken of it by all the outstanding groups in American medicine. It is vigorously opposed by the A.M.A., A.B.S., and the Council on Medical Education and hospitals of the A.M.A., as is proven by the following quotations:

"A resolution adopted by the House of Delegates of the American Medical Association in 1946:

'Resolved, that hospitals should be encouraged to establish general practitioner services. Appointments to a general practice section shall be made by the hospital authorities on the merits and training of the physician. Such a general practice section shall not per se prevent approval of a hospital for the training of interns and for residencies.

'The criterion of whether a physician may be a member of a hospital staff shall not be dependent on certification by the various specialty boards or membership in special societies.'

and

"A report of the Council on Medical Education and Hospitals of the American Medical Association:

'It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board-certified physicians as is now the policy in some hospitals. Such policies, if practiced extensively, are detrimental to the health of the people, and therefore to American medicine. Hospital staff appointments should depend on the qualifications of physicians to render proper care to hospitalized patients as judged by the professional staff of the hospital and not on certification or special society memberships. In this opinion, the council has the full concurrence of the Advisory Board for Medical Specialties.'

and

"A resolution adopted concurrently by the American Board of Surgery and the Advisory Board of Medical Specialties:

'The American Board of Surgery is not concerned with measures that might gain special privileges or recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board of Surgery to define requirements for membership on the staff of hospitals. The prime object of the board is to pass judgment on the education and training of broadly competent and responsible surgeons—not who shall or shall not perform surgical operations. The board specifically disclaims interest in or recognition of differential emoluments that may be based on certification.' "

Effect on General Practitioner

Barring the general practitioner not only decreases the incentive for our younger graduates to enter general practice but it also has another deleterious effect—namely, those men now in practice who do not have hospital privileges become stagnant and retrogressive practitioners and are responsible for the poor quality of medical care rendered in some areas. A medical man must be in association with men who are his peers in order to enhance his knowledge.

Another compelling reason why competent general practitioners must be accorded hospital privileges is the changing concept of medical economics. With the advent of Blue Cross and, here in Rhode Island, of our Physicians' Service, which offers not only surgical and obstetrical benefits but also medical service, more and more people are being treated in the hospitals. Many of these were treated at home before voluntary insurance was sold. Thus, more and more of the general practitioner's patients are being weaned from him.

Paradoxically, the trend toward over-specialization is giving the general practitioner an ever more important role in medicine. As the specialties multiply and become more complex, and their techniques more difficult, there is an increasing need for the highly educated doctor with a wide outlook and wide knowledge, who knows his patient, his environment and family background, and can view his case as a whole.

Technical advances in medicine, the antibiotics and the newer chemo-therapeutics have also increased the value and the services the general practitioner can render, and have made him even more indispensable to the health of the individual.

This trend toward over-specialization is a matter of serious concern and it must be reversed if American medicine is going to remain a free enterprise. The only way to reverse this trend is to make better general practitioners who, through self improvement, can command the respect of the laity and the rest of the profession.

Tonight I am here as a representative of the American Academy of General Practice, namely as President of the Rhode Island chapter. This is a group of outstanding American medical men who have recognized the need of improving the status and the ability of the general practitioner, and once more, through this improvement, regain for him the prestige and rights which he formerly possessed.

continued on next page

This is not a pressure group organized to exert pressure or to obtain privileges for incompetent individuals. Ninety percent of its membership now have hospital privileges.

I ask you only to view our objectives with an open mind. We do not wish to be patronized. We feel that the general practitioner has considerable to offer to the hospital and the specialists. We know that we, in turn, shall be greatly benefited from this association. We do not seek privileges without accepting the responsibility that goes with privileges. We ask that you judge each and every one of us solely on our qualifications.

Dr. McCormick, a member of the Board of Directors of the A.M.A., Chief of Surgery at Maumee Hospital, Toledo, Ohio, Past President of the Ohio State Medical Society, and on whose hospital staff general practitioners have been integrated for fifteen years, said: "When the general practitioner has received the recognition to which he is justly entitled, he grows in knowledge by contact and becomes more proficient, renders better service to his patients and, because of professional association and advice, does not attempt to walk in where angels fear to tread."

Objectives of Academy

I would now like to discuss with you the objectives of the American Academy of General Practice which I think are most commendable:

1. To establish an organization of general practitioners and maintain high standards of general practice.
2. To assist young men in preparing, qualifying and establishing themselves in general practice.
3. To preserve the right of the general practitioner to practice in the hospital to the extent of his ability.
4. To assist in providing postgraduate training for the general practitioner.
5. To promote the art of surgery and medicine for the betterment of public health.
6. To preserve the right of free choice of physician.

What has the American Academy of General Practice done to accomplish these objectives?

1. It has established an organization for general practitioners. There are now approximately 15,000 members, which is a phenomenal growth for a medical organization that is just over two years old. It is the third largest group of organized medical men in the country. We propose to maintain high standards of general practice by requiring that each member must complete 150 hours of postgraduate training every three years. One hundred hours of this may be accomplished by attending staff conferences, clinics, medical seminars or symposiums, and by attendance at state county or local Medical Society meetings. The other fifty hours must be obtained by attending an institution where formal instruction is rendered and which is approved by the Academy. A member cannot renew his membership unless this requirement is fulfilled every three years. This is the only medical organization that I know of which has such a requirement. You certainly will agree with me that such a program is going to stimulate our members. No longer will the general practitioner be looked down on as the man with the proverbial black bag and a few pills, and nothing to offer but his ingenuity and consolation, but in his stead we will offer well trained, well informed and competent up-to-date medical practitioners.
2. There are now in the United States 85 hospitals which have 216 general practice residencies. These residencies vary from two to three years in duration and are designed to give the student a well rounded and well balanced training and background for general practice. Some of our leading schools are offering this program—the Universities of Louisiana, Colorado, Louisville, Kansas and others. This program certainly is going to assist young men to prepare themselves for general practice.
3. Retain the right of the general practitioner in the hospitals.

   There are at present 837 hospitals that have general practice sections. Of course, there are many others that allow general practitioners privileges but these hospitals actually have general practice sections. This section is an integral part of the hospital staff. It is headed by a general practitioner who is elected from the section, and he has a voice in determining staff policy. He sits in at staff meetings with the chiefs of the other sections and has an equal voice. The men in the general practice section conduct their own conferences and discuss their problems. They must attend at least 75% of the staff conferences. They have responsibilities of teaching the intern and residents. The men applying for privileges in this section are judged by the qualifications and credentials committee just as their brother specialists. These men are then given privileges in keeping with their qualifications. There is no overstepping of their privileges because these are clearly defined.

   The University of Louisville now has a department of general practice in its Medical School. This department is headed by a member of the American Academy of General Practice. Finally the student will become

continued on page 364

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

POLLUTION

The morning paper shows Governor Pastore turning a valve to divert a daily flow of 4,000,000 gallons of raw sewage from Bucklin Brook into a modern system where it will be properly treated. He was assisted in this pleasant manual labor by Chairman Halloran of the Blackstone Valley Sewer District Authority.

This organization was not in existence and apparently not even contemplated four years ago when the committee on Water Pollution of the Providence Medical Association made its report and this journal followed it with an editorial.

There's a lot of water gone under Red Bridge since then, unfortunately very nasty. But when the Governor turned the valve he stopped some of the filth. Undoubtedly a good start has been made towards decency with more improvement to follow.

We said four years ago that large industries really wanted to cooperate by handling their industrial waste properly. The community was in no position to insist on huge outlays by private interests until human sewage was taken care of. In this connection it was encouraging to read recently a statement by Mr. Shea, Chief, Division of Sanitary Engineering, that one of the largest concerns discharging chemicals into our water is willingly planning to change its ways.

The Rhode Island Medical Journal incurred the displeasure of the Navy not long ago by pointing out that the shore installations at Newport were pouring great amounts of sewage into the harbor. Now we learn that the money is appropriated and this evil is at long last going to be corrected.

A volunteer state committee on pollution has recently made their report in which there is a good deal of detailed optimism about the conditions throughout the state. Such places as the state institutions have remedied what was before decidedly bad.

This is all very encouraging but a series of diagrams recently published in the daily press shows large areas of solid blackness. These areas are not clean and they will not be clean even with what we have done and have planned definitely so far.

The problem is a considerable one and we have got to keep pestering the powers that be or they will most certainly slacken.

The problem of air pollution has also been improved. We have a good official setup for this and a good man at the head of it. We think we can see even now a little improvement. The east side of the city does not have so much grit under foot as formerly. Probably a good deal of this is due to the shift from coal burning locomotives to diesel engines on the railroad.

Certainly our own court house has ceased to be the bad offender that it was. We hear that they are

continued on next page

going to be tough on improper soft coal installations. Once again we voice some optimism about this problem and an admonition that we have to keep working hard.

DOCTORS MUST VOTE

"Politics and medicine don't mix!"

Statements like this frequently are employed by many doctors to justify their failure to register, failure to vote and failure to take part in the political decisions of the local community, the State and the Nation.

Added to this viewpoint is the indisputable and somewhat extenuating fact that the best doctors are extremely busy people, engaged in the night-and-day task of preserving health and saving life.

Nevertheless, this year of decision, 1950, presents American doctors with an undeniable paradox: doctors either must enter the political arena or see politics enter medicine.

For this is not just another election year. It is a year in which medicine itself will be one of the big clay pigeons on the political shooting ranges. The question of Compulsory versus Voluntary Health Insurance—embodying the future not only of the medical profession but of all the American people — will be one of the principal issues in the 1950 Congressional elections.

It is imperative, therefore, that every doctor exercise his franchise this year — his right *as an individual citizen* to register, to vote, and to help influence the political direction of his Nation.

Failure to do so, this year, may mean the ultimate termination of his traditional medical franchise — the right to practice medicine according to ethical professional and scientific standards — not political standards.

ANNUAL REPORTS

Annual reports of committees are not easy to write, as any chairman will attest. They undoubtedly are not always easy reading, for they are concerned in the main with a recount of past work, and a summarization of achievement attempted, gained, or to be sought at a future date.

But they constitute reading that is of vital interest to every Fellow of the Society. The service on committees of the Society, whether elected or appointed, is a service of love. The good of the profession, the advancement of medical science and of public health, and general service to the community in every way possible are tied into the assignment of committee service. To the Fellows who annually accept the task of carrying forward the many activities of the Society, who give unstintingly of their time and energy to meet regularly and to work out the problems of the moment, we all owe a great debt.

The publication of these annual reports is not merely to satisfy the by-laws providing that the Journal shall be the means of publicizing the work of the Society. They appear as information of vital importance to every physician. They stand as a challenge to every Fellow to take it upon himself to become interested in committee work, and to volunteer either to serve on a committee, or to contribute his ideas for the advancement of the work of any and all committees.

DENTAL HONORS

The nation's foremost dentists were singled out for distinction last month in an honor roll published in a special mid-century issue of the Journal of the American Dental Association, commemorating 50 years of dental progress, and the Rhode Island "dentist of the half century" was the late Dr. Charles Albert Brackett of Newport.

Dr. Brackett was nominated for the honor by members of the Rhode Island State Dental Society for his leadership both in the field of dental education and in organized dentistry.

He was one of the founders and a president of the state dental society and served as president of the state board of registration for nine years.

Following his graduation from Harvard Dental School, he served on its faculty and was a member of the school's first administrative board. For the furtherance of dental education, he contributed more than $400,000 to the school.

In tribute to the educator, the late Dr. Charles W. Eliot, president of Harvard, said:

"Dr. Brackett's influence will give to coming generations an invaluable lesson on the immortal worth of character, gentle manners, unselfishness and public spirit."

Dr. Brackett was well-known to the medical profession of this State, and his contribution to the advancement of the professions and the dental health of the public warranted his selection for the historic listing by the national dental association.

CHARITY A "CURSE"?

Oscar Ewing, federal security administrator, received the Sidney Hillman $1,000 annual award for meritorious public service. The prize was presented by Jacob S. Potofsky, who succeeded the late Mr. Hillman as president of the Amalgamated Clothing Workers. It was awarded for Mr. Ewing's work on behalf of "social security," notably compulsory national health insurance. In the course of his remarks, Mr. Potofsky praised the health insurance scheme as a plan that would "destroy the curse of charity" and bring the "best in medical care to everybody."

Charity has been regarded for a long time as a beautiful and noble virtue—"And now abideth faith, hope, charity, these three; and the greatest of

these is charity." But in describing charity as a "curse," Mr. Potofsky meant that those who accept help from others may feel humiliated over their inability to do for themselves.

If it were merely insurance that would end this "curse," it is already available—and from nonprofit institutions. But the Ewing "meritorious public service" requires two other things. One is compulsion from the government to make sure that everyone is insured. The other is large sums from the taxpayers to make up the deficits in the fund collected from the insured.

Assistance given by one or several persons to others in need is "charity" and a "curse." When that assistance is taxed away from all, it is, in the Ewing-Potofsky-New Deal view, no longer "charity" but a "right."

It strikes us that here is the key to the New Deal philosophy. It is the effort to give the less fortunate and the less successful a vested right to be aided by the taxes taken from the successful, the fortunate and the thrifty. The donors are entitled to no appreciation for their contribution: the recipients owe nobody thanks, for charity is a "curse." The extent to which this conception of charity has been accepted may not be generally realized. The Maine farmer who deliberately grows potatoes in unsalable quantities does not feel indebted to his neighbors for getting him out of his hole. He has a "right" to receive from the taxpayers a profit on his unsound venture.

The entire social security program of pensions, unemployment insurance and the like is based on the notion that individuals must be forced to make for themselves and their fellows the provision decreed by an all-wise bureaucracy. The Christian principle of benevolence toward one's neighbors has been converted into a compulsory wealth-sharing, in which any gratitude of the beneficiary is not to the contributor but to the politician who extracted the benefits for him.

Probably this system is now so well accepted that few would change its present applications. But thoughtful people will consider its extension carefully. For once this principle is completely established, all that anyone owns will be held subject to the demands of those who have less, since the "right" of the latter will be cemented, and the exercise of it be limited only by the zeal of their political spokesmen in carrying out the leveling process.

That is why the seeds of Socialism, Communism, or totalitarianism by any other name, are correctly imputed to New Dealism. That is why the worst enemies of democracy, the most violent reactionaries, are those who deny the ability of a free people to manage their own affairs, to dispense their own charity, and who insist that the government become the social guardian who makes and enforces all such decisions.

While the New Dealers in this country have so far sought only to make charity a "curse," other parts of the world have gone farther and made faith a curse also.

Hope, fortunately, is still permissible everywhere.

(Editorial, Chicago Daily News, 3/16/50).

PHYSICAL MEDICINE CONGRESS AT BOSTON

Will hold its twenty-eighth annual scientific and clinical session August 28, 29, 30, 31 and September 1, 1950 inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on the days of August 28, 29, 30, 31 and September 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30 and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Mrs. William N. Hughes, (left) retiring president of the Woman's Auxiliary, discusses plans for the future with Mrs. Charles L. Farrell, incoming President, at the annual meeting of the Auxiliary.

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Balance Sheet — May 31, 1950

ASSETS

Cash in Banks and On Hand:	April 30, 1950	May 31, 1950	Increase (Decrease)
Operating Account	$58,018.01	$89,635.56	$31,617.55
Accounts Receivable (Subscriptions)	109.97	153.65	43.68
TOTAL ASSETS	$58,127.98	$89,789.21	$31,661.23

LIABILITIES

Accounts Payable (Surg.-Med. Services)	$ 8,456.00	$20,291.00	$11,835.00
Accounts Payable (Hospital Serv. Corp.)	2,022.27	2,669.40	647.13
Accounts Payable (R. I. M. S.)		2,000.00	2,000.00
Accrued Surgical-Medical Expense	20,857.00	32,491.00	11,904.00
Unearned Subscriptions	1,914.65	4,187.30	2,272.65
TOTAL LIABILITIES	$32,979.92	$61,638.70	$28,658.78
Reserves:			
Surgical-Medical Expense	$25,148.06	$28,150.51	$ 3,002.45
TOTAL LIABILITIES AND RESERVES	$58,127.98	$89,789.21	$31,661.23

Statement of Income and Expense

	Month of April, 1950	%	Month of May, 1950	%	Total to Date 5/31/50	%
Income:						
Earned Subscriptions	$30,737.60	100	$39,866.85	100	$112,968.05	100
To Surgical-Medical Reserve	$28,323.53		$35,197.45		$101,764.51	
To General Reserve	2,414.07		4,669.40		11,203.54	
Surgical-Medical Expense:						
Participating Physicians	$15,292.00		$27,731.00		$ 64,520.00	
Non-Participating Physicians	2,269.00		4,464.00		9,094.00	
Total Surgical-Medical Expenses	$17,561.00	57.1	$32,195.00	80.8	$ 73,614.00	65.2
Total Operating Expenses	$ 2,414.07	7.9	$ 2,669.40*	6.7	$ 9,203.54	8.1
Organization Expenses Appli. to 1949			$ 2,000.00	5.0	$ 2,000.00	1.8
Added to Reserves	$10,762.53	35.0	$ 3,002.45	7.5	$ 28,150.51	24.9
Surgical-Medical	$10,762.53		$ 3,002.45		$ 28,150.51	

Monthly Income and Expenses — 1950

	Earned Income	Surgical-Medical Expense	Operating Expense	Net Income Added to Reserves
1 '50	$ 9,074.10(100%)	$ 4,790.00(52.8%)	$ 660.71(7.3%)	$ 3,623.39(39.9%)
2 '50	13,341.35(100%)	7,012.00(52.6%)	924.42(6.9%)	5,404.93(40.5%)
3 '50	19,948.15(100%)	12,056.00(60.4%)	2,534.94(12.7%)	5,357.21(26.9%)
4 '50	30,737.60(100%)	17,561.00(57.1%)	2,414.07(7.9%)	10,762.53(35.0%)
5 '50	39,866.85(100%)	32,195.00(80.8%)	4,669.40(13.7%)	3,002.45(7.5%)

*Expenses Charged By Blue Cross Under Operating Agreement — $2,669.40 (6.7%)

continued on page 363

Enrollment by Months

	CONTRACTS				SUBSCRIBERS				
Month	*"P"*	*"C"*	*"D"*	*Total*	*"P"*	*"C"*	*"D"*	*Total*	*Avg. Sub. Per. Contr.*
1 '50	1,418	3,844	6	5,268	3,844	7,996	16	11,856	2.25
2 '50	1,774	849	25	2,648	4,072	1,795	59	5,926	2.24
3 '50	2,351	1.108	38	3,497	6,007	2,283	76	8,366	2.39
4 '50	4,755	1,231	40	6,026	10,802	2,605	81	13,488	2.24
5 '50	2 183	2,910	110	5,203	5,169	6,762	249	12,180	2.34
*6 '50	2,904	2,009	.....	4,913	6,178	4,923	.....	11,101	2.26
Net 6/1/50 (Before Cancellations)				27,634				63,141	2.28

* Preliminary Figure

Report of Surgical and Medical Expenses

		Month of May 1950			Total to Date May 31, 1950		
		Cases	Amount	C. P. Case	Cases	Amount	C. P. Case
SURGEONS	Hospital	276	$15,705.00	$56.90	533	$30,797.50	$57.78
	Office-Home	54	908.00	16.81	151	2,539.00	16.81
	Total	330	16,613.00	50.34	684	33,336.50	48.74
ASSISTANTS . . .	Hospital	45	640.00	14.22	98	1,417.50	14.46
	Office		.....	.....	2	20.00	10.00
	Total	45	640.00	14.22	100	1,437.50	14.38
ANESTHETISTS . .	Hospital	180	2,252.00	12.51	345	4,560.00	13.22
	Office	15	124.00	8.27	31	256.00	8.26
	Total	195	2,376.00	12.18	376	4,816.00	12.81
TRANSFUSIONS . .	Hospital	3	20.00	6.67	8	45.00	5.63
MEDICAL	Hospital	24	642.00	26.75	58	1,488.00	25.66
TOTAL REPORTED .	Hospital	528	19,259.00	36.48	1,042	38,308.00	36.76
	Once-Home	69	1,032.00	14.96	184	2,815.00	15.30
TOTAL PAID		354	20,291.00	51.10	742	41,123.00	55.42
ACCRUAL FOR UNREPORTED .		193	11,904.00	34.68	584	32,491.00	55.64
TOTAL EXPENSE		547	32,195.00	42.32	1,326	73,614.00	55.52
PARTICIPATING PHYSICIANS . . .			27,731.00			64,520.00	
NON-PARTICIPATING PHYSICIANS .			4,464.00			9,904.00	
MONTH INCURRED:							
January '50			161.00			3,410.00	
February '50			310.00			5,749.00	
March '50			1,530.00			8,694.00	
April '50			7,526.00			12,506.00	
May '50			10,764.00			10,764.00	
TOTAL PAID			$20,291.00			$41,123.00	

PROBLEMS OF GENERAL PRACTICE AND THEIR SOLUTIONS

concluded from page 356

aware of the fact that there is such a doctor as the general practitioner before he becomes an intern.

4. To provide postgraduate training.
   Last year in more than 60 institutions there were courses offered at which the family physician could obtain his 50 hours of formal postgraduate instruction. The ensuing year will find many more institutions offering such courses.
5. Our fifth aim was to improve and promote the art of medicine and surgery for the betterment of public health. This objective will be accomplished because of accomplishment of the previous four which will give us more competent and better trained general practitioners.
6. We will preserve the right of free choice of a physician because more men will be induced to enter the field of general practice and, therefore, the rural areas will obtain the medical care for which they have been clamoring and for which they have been in such dire need. This is the one complaint that the socializers have against the medical profession for which we cannot offer satisfactory rebuttal. This program will correct that fault.

Membership in the Academy is open to men who are:

1. Graduates of Class A medical schools and who have served an approved internship.
2. Members of their local, county or state medical societies.
3. Of good moral character, and who have shown an interest in post graduate work.

Progressive Program Contemplated

We do not want agitators, or those who have axes to grind, or malcontents. We are looking for the competent and capable general practitioner, and we hope that by improving him we will be able to raise the level of others.

You certainly will agree with me that this is a forward, progressive, constructive program which is rapidly accomplishing its purpose. However, the real improvement will be to the patients who will find available to them high class medical service conveyed by men and women in whom they have great confidence as a result of intimate contact. The great problem of medical cost will be partially resolved by the more general and less specialized advice. The first haven our grandfathers sought when illness struck was the family physician, and our younger generation must be taught that it should still be the family physician.

There is no one in the medical profession who has a greater claim on hospital recognition than the G. P. He or she does not wish to teach surgery, gynecology or radiology, or any other specialty. Nor do they desire promotion above their merits and qualifications, and such recognition should not be accorded. There is, however, a great chasm between over-recognition and exclusion. Neither is justifiable. The betterment of the profession, the expansion of hospital and medical service to the public, and the good of the public health from a scientific and financial viewpoint demand that those of you in the fields of standardization, hospital administration and specialty practice "render to Caesar the things that are Caesar's." Never in the history of American medicine has such a course been more necessary than the present time, as it is conceivable that the fundamentals of American democracy may hang in the balance.[2]

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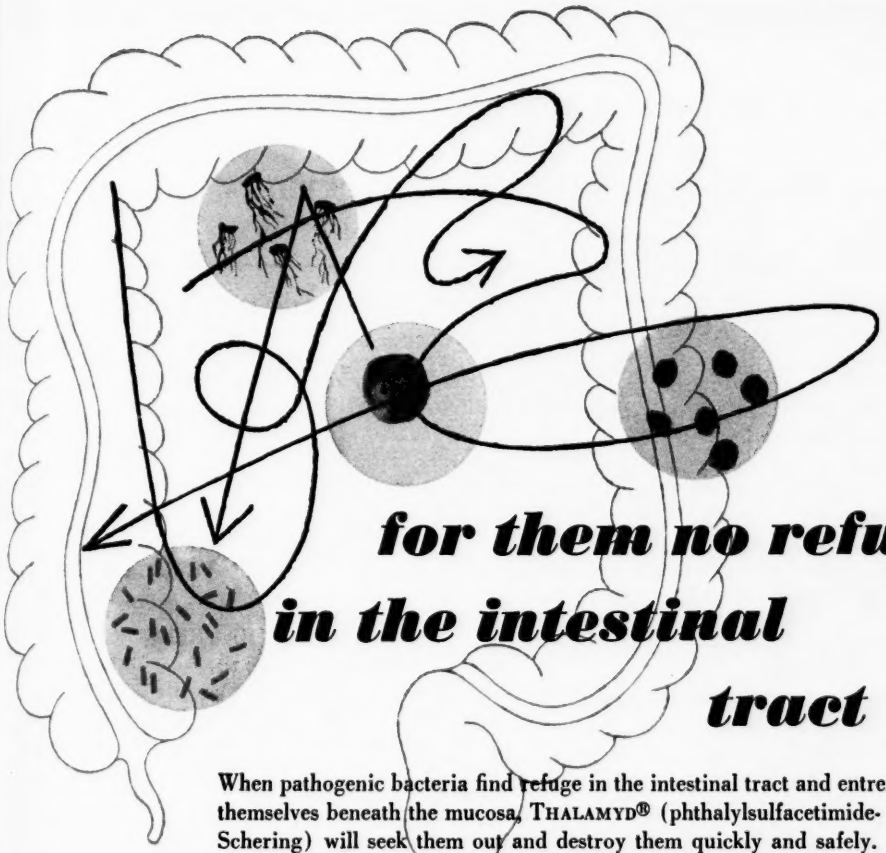

for them no refuge in the intestinal tract

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SCHERING

ANNUAL REPORTS—1949-50

THE RHODE ISLAND MEDICAL SOCIETY

GENERAL MEETING . . . MAY 11, 1950

In accordance with the By-Laws of the Society a general meeting open to all registered members and guests was held at noon on Thursday, May 11, 1950, the second day of the 139th Annual Meeting. The meeting was called to order by Dr. Peter Pineo Chase, the President.

The Secretary reported the slate of officers and elected committees elected by the House of Delegates at its May meeting.

Dr. Charles J. Ashworth, president-elect, was escorted to the platform, and he addressed the membership briefly. The other officers elected by the House of Delegates were called individually to be recognized by the meeting.

The Secretary reported that at its meeting on May 3 the House of Delegates had adopted the report of the Committee on the revision of the by-laws, and he read the report of the committee, citing the proposed by-law changes.

It was moved, seconded and unanimously voted that the proposed changes in the by-laws be adopted.

The meeting was adjourned by the President.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

BOARD OF TRUSTEES

During the past year the Board of Trustees has authorized the Providence Medical Association to establish its Medical Bureau, a 24-hour secretarial telephone exchange for the medical profession, in the basement room.

The addition of this facility has demonstrated anew the potential value of the building to the Profession. The Providence Medical Association has guaranteed the cost of improvements in the basement, including the partitioning of the room, the installation of lights, and new flooring.

A new electric drinking cooler has been installed on the first floor of the library.

Recently the Trustees were faced with a sizable expenditure for a new boiler to replace the one that has been used since the building was erected in 1912. We are faced annually now with the deterioration of some of our equipment, and we must anticipate annual expenditures for property repairs.

The Council has authorized the Trustees to study and report to it regarding the heating system of the building, with the thought in mind that the coal burning equipment might be changed to oil burning. The new boiler recently purchased will lend itself to such a changeover.

Within the next few months an addition to the heating system will have to be installed to provide adequate heat for the Medical Bureau in the basement.

Respectfully submitted,
BOARD OF TRUSTEES
EDGAR S. POTTER, M.D., *Chairman*

REPORT OF THE TREASURER

The cost of operation of the Society during 1949 was approximately $3,600 more than the previous year, due in major part to the increasing activity of the Society's many committees, plus the rising costs in general for all utilities, equipment, and building maintenance.

Although our cash balance at the end of 1949 was approximately $2,700 less than that available at the end of the previous year, this difference is offset by the fact that we have accounts receivable from loans to the Rhode Island Medical Society Physicians Service in the amount of $2,000, and from the Providence Medical Association in the amount of $795.67. Thus our assets were slightly higher as of January 1, 1950, than they were the first of the previous year.

Our invested reserve of general funds is $5,000 which is invested in U. S. Treasury securities.

The activities of the Society in recent years have greatly increased. We now have two general meetings a year, our annual meeting has been expanded, the cancer, diabetes, and public relations committees, for example, have carried forward extensive programs for the membership, and the national meetings in which we must have representation are numerous. All these important activities make increasing demands upon the finances of the Society.

The Medical Library is an old building, and each year we are faced with a new problem of repair. Recently a new boiler had to be installed at great expense, and the entire heating system has to be re-studied.

The various special funds of the Society have remained unchanged during the year, except that

continued on page 368

SPOIL THE APPETITE . . .

CONTROL OF APPETITE is frequently beyond the power of human will, a fact that explains most cases of obesity. Fortunately, appetite can be checked by administration of certain sympathomimetic drugs, such as *Propadrine*® phenylpropanolamine HCl, a development of Sharp & Dohme research notably free of the unpleasant side effects associated with ephedrine. ALTEPOSE tablets, a new formula for control of obesity, provide PROPADRINE HCl, 50 mg. (¾ gr.), to reduce the desire to eat; *thyroid*, 40 mg. (⅔ gr.), to increase metabolism; and DELVINAL® vinbarbital, 25 mg. (⅜ gr.), for mild sedation. ALTEPOSE tablets spare the obese patient the pangs of hunger, making low-calorie diets more acceptable, speed metabolism of excess fat and carbohydrate, and tend to suppress nervous tension and anxiety. The proper dose must be determined for each individual. ALTEPOSE tablets are supplied in bottles of 100 and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

spare the patient

SHARP & DOHME

Altepose® TABLETS

for treatment of obesity

ANNUAL REPORTS

continued from page 366

the income from the various investments continues to be low.

The Medical Journal continues to meet its operative costs from its own advertising and circulation revenue, and therefore has not required any financial assistance from the Society.

* * *

REPORT OF THE TREASURER

Fiscal Year — 1949

Cash balance, General Fund, January 1, 1949	$11,921.03
Receipts, 1949 (Exhibit A)	33,903.57
Total	$45,824.60
Expenses, 1949 (Exhibit B)	$36,638.56
Balance	$ 9,186.04

* * *

Cash on hand, General Funds, January 1, 1950	$ 9,186.04
Cash in general funds credited to Special Funds (Exhibit C)	*—1,769.18*
Cash on hand for Operating Expenses, January 1, 1950	$ 7,416.86

* * *

Cash on Hand in General Funds, January 1, 1950	$ 9,186.04
Accounts Receivable:	
Rhode Island Medical Society Physicans Service	2,147.78
Providence Medical Association, Medical Bureau	795.67
Invested Funds, U. S. Treasury Certificates	5,000.00
Total assets, January 1, 1950	$17,129.49

EXHIBIT A — RECEIPTS — 1949

Annual meeting, dinner payments	$ 1,470.00
Council Meetings, dinner receipts	168.00
Dividends from invested funds	750.58
Donations	65.00
Dues from members	26,800.00
Exhibits, balance due for 1949 meeting	1,449.50
Midwinter meeting, dinner receipts (February 4)	462.50
Midwinter meeting, dinner receipts (December 14)	427.00
Miscellaneous (Reimbursements from AMA, New England Medical Council, Conference of Presidents, Medical Bureau, etc.)	758.10
Providence Medical Association	1,552.89
Total	$33,903.57

* * *

EXHIBIT B — EXPENSES — 1949

Annual Meeting, including dinner payments	$ 3,523.48
Books	223.55
Committees:	
Arrangements for Annual Meeting	24.24
Cancer	267.45
Diabetes	171.00
Health Insurance	57.00
Medical Grievance	3.75
Public Relations	217.59
Council meetings, dinner payments	302.83
Delegates to AMA and national meetings	871.33
District Societies' Officers Conference	92.67
Donations and dues to Organizations	120.00
Electricity	79.69
Fuel	758.75
Gas	53.42
General Expenses (Society)	1,240.50
Insurance	1,295.28
Legal	609.74
Library	1,122.75
Loans (Medical Bureau, Providence Medical Association)	345.83
Midwinter meetings, including dinner payments	1,209.21
Office supplies and equipment	975.77
Postage	486.17
Printing	772.90
Repairs, Library building	338.15
R. I. Medical Society Physicians Service (loan)	2,154.78
Salaries	17,264.45
Taxes	1,708.30
Telephone	347.98
Total	$36,638.56

EXHIBIT C — SPECIAL FUNDS — 1949

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1,500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

Investments

52 shares, New England Electric Company

Cash in General Fund of Society

Balance January 1, 1949	$ 770.65
Stock dividends, 1949	41.60
Total	$ 812.25
Periodicals purchased, 1949	132.50
Cash balance in General Fund, January 1, 1950	$ 679.75

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continued on page 370

ANNUAL REPORTS

continued from page 368

ENDOWMENT FUND

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2 1/12 of the annual income, amounting that year to $69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

Investments

U. S. Treasury Bonds	$2,000.00	
Dividend, 1949		$ 50.00
74 Shares, Providence Gas Company	906.50	
Dividend, 1949		37.74
Total		$ 87.74
Used for Library Building Maintenance		$ 87.74

* * *

E. M. HARRIS FUND

Established in 1921 by a donation of $5.000 by Dr. E. M. Harris for "upkeep of the Library Building."

Investments

25 shares, Consolidated Edison Electric Company
64 shares, Nicholson File Company
Dividends, 1949 (Used for upkeep of Library Building)

Consolidated Edison Electric Company	$ 125.00
Nicholson File Company	192.46
Total	$ 317.46

* * *

HERBERT TERRY FUND

Established in 1928 by a donation of $2,000 from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

Investment

96 shares, Providence Gas Company

Cash in General Funds of Society

January 1, 1949	$ 4.30
Dividends, 1949	48.96
	$ 53.26
Books and periodicals purchase, 1949	61.00
Loss (Paid from general funds)	$ 7.74

* * *

JAMES R. MORGAN FUND

Established by a donation of $500 in 1929 to be used for current expenses.

Investment

43 shares, Providence Gas Company
Dividends, 1949 (Used for current expenses) $ 21.93

* * *

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

Investment

89 shares, Providence Gas Company

Cash in General Fund

January 1, 1949	$ 1,016.77
Dividends, 1949	45.39
Total	$ 1,062.16
Books purchased, 1949	— 14.30
Cash balance in General Fund, January 1, 1950	$ 1,047.86

* * *

THE CHARLES F. GORMLY FUND

Established by the Society in 1945 with a cash balance of $102.51 accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Society in 1943. The Fund was established for the purchase of medico-legal books to form the Charles F. Gormly collection.

Cash balance in General Fund, January 1, 1949	$ 58.32
Books purchased, 1949	16.75
Cash balance in General Fund, January 1, 1950	$ 41.57

* * *

continued on page 372

appetite must be controlled

"The greatest problem in preventive medicine in the United States today is obesity."[1] And today it is well-known that *"The only way to counteract obesity . . . is by a restriction of food intake."*[2]

'Dexedrine' Sulfate controls appetite, making it easy for the patient to avoid overeating and thus to lose weight safely without the use (and risk) of such potentially dangerous drugs as thyroid. In weight reduction 'Dexedrine' *"is the drug of choice because of its effectiveness and the low incidence of undesirable side effects."*[1]
Smith, Kline & French Laboratories • Philadelphia

Dexedrine* Sulfate tablets • elixir

A most effective drug for control of appetite in weight reduction

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.
2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

ANNUAL REPORTS

continued from page 370

FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

Investment

3,000 shares, Canadian National Railway Company

Cash, Industrial Trust Company, checking account		
Balance, January 1, 1949		$ 678.45
Dividends, 1949, Canadian National Railway		135.00
		$ 813.45
Books purchased and Bank charges, 1949		$ 133.43
Balance, January 1, 1950		$ 680.02
Assets:		
Cash balance, January 1, 1949		$ 1,195.26
Receipts, advertising and subscriptions		14,072.56
		$15,267.82
Expenses:		
Copyrights	$ 48.00	
Editorial Staff	118.29	
Postage	247.30	
Printing Journals	11,160.06	
Printing, (Misc.)	337.03	
Refund	2.00	
Supplies and Equipment	17.65	
Editor's Expenses	1,040.00	
		$12,970.33
Total	$12,970.33	
		$ 2,297.49
Cash balance 2/7/50	$ 2,297.49	
Accounts Receivable		
Blanding & Blanding	25.00	
Brewer Company	21.25	
Desitin Chemical Co.	42.50	
Assets, February 7, 1950	$ 2,386.24	

G. RAYMOND FOX, M.D., *Treasurer*

Scientific Work and Annual Meeting

The Committee on Scientific Work and Annual Meeting carried out the request of the House of Delegates that the midwinter meeting be held in December, and a session was held at Newport, Rhode Island, on December 18, 1949. Guest speakers at this meeting were Dr. Wingate Johnson, of North Carolina, Dr. Meyer Saklad of Providence, and Dr. Creighton Barker of New Haven, Connecticut. The meeting was well attended.

The Committee has completed plans for the 139th Annual Meeting of the Society to be held at Providence on May 10 and 11, and it anticipates that this session will prove of great scientific value to every Fellow of the Society.

The midwinter meeting for this year has been set for Wednesday, December 13, 1950, and it will be held in Woonsocket, Rhode Island.

Respectfully submitted,

CHARLES J. ASHWORTH, M.D., *Chairman*

REVISION OF THE BY-LAWS

At the request of the Council of the Society a committee on the revision of the by-laws was appointed, and it submits herewith a summary of the revisions it would recommend to the House of Delegates for approval, and for submission to the General Session of the Society to be held on May 11, 1950.

The Committee has endeavored to clarify the by-laws in accordance with the present operation of the Society, and in accordance with previous amendments that have been adopted from time to time. The summary below indicates the revisions that would be made. The text of the official regulations with these amendments indicated, will be available for inspection by the House of Delegates on May 3.

Respectfully submitted,

ROLAND HAMMOND, M.D., *Chairman*
JOHN E. DONLEY, M.D.
G. RAYMOND FOX, M.D.

Summary of By-Law Changes Proposed

ARTICLE III. *Membership*

Section 7 is amended to provide that dues shall be payable within the calendar year before suspension is effective. The present rules sets October 1. The pro rating of dues is also eliminated in view of the fact that members elected in the latter part of the year have their dues applied for the ensuing year.

* * *

ARTICLE IV. *Component Societies*

Section 6 is amended to provide for the election of alternate Councillors.

* * *

ARTICLE V. *Officers*

Section 1 is amended by deleting provision for the office of assistant secretary. All future reference to assistant secretary in the by-laws is also eliminated.

Section 9 is amended to provide that the Secretary shall be ex officio a member of all Standing Committees.

Section 9 change word "member" to "Fellow" in lines 14, 17, and 23. Change word "membership" to "Fellowship" in line 18.

Section 11 is amended to provide that the annual budget shall be presented at the September meeting of the House of Delegates.

* * *

ARTICLE VI. *House of Delegates*

Section 3 is amended by deleting the provisions that the Council shall set the order of business for the House of Delegates.

Section 4 is amended to provide that the month of April, instead of the month of May, shall be set for one of the meetings of the House of Delegates.

Section 7 is amended to provide that the AMA delegates shall be elected in September and take office the following January 1 for two year terms.

Section 7 also amended to provide that the Council shall name a Nominating Committee of 5 of its own members to prepare a list of candidates for offices and standing committees, and the Council will then review the list and submit a final list to the House of Delegates.

* * *

ARTICLE VIII. *Sessions and Meetings*

Section 2, line 3, change word "members" to "Fellows."

Section 7 is amended to provide that papers read at meetings shall not exceed 30 minutes instead of 20 as now provided.

This section also amended to remove present unworkable provisions relative to the Society's claim on scientific papers presented at annual and special meetings.

* * *

ARTICLE IX. *Finance*

Change word "members" to "Fellows" section 1, line 3.

* * *

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ARTICLE X. *Standing Committees and Boards of Trustees*

Sections 1 to 15 amended to provide as follows: Correct committee titles based on previous amendments. Addition of Medical Grievance and Defense as standing committee, and definition of its work.

All committees to be composed of 9 members elected by the House of Delegates, in addition to the President and the Secretary, ex officio.

Section 8 where word "members" is used substitute "Fellows."

* * *

All sections or parts of sections and articles as presently written that are inconsistent with these proposed amendments would be amended accordingly to carry out the full and true intent of the revisions proposed above.

CANCER

The activities of the Committee this year have consisted principally in the preparation and the putting on of the second annual Cancer Conference. This Conference included as speakers men of reputation in the field of cancer who spoke on early diagnosis and treatment. The meeting was well attended, and the papers were excellent.

In addition to the activities concerned in this conference, the Chairman, who is an ex officio member of the Board of Directors of the Rhode Island Cancer Society, has attended numerous meetings both of the Board of Directors and of the Executive Committee.

At present, plans are well underway in arranging for a third annual Cancer Conference which will be held on October 18, 1950, at the Medical Library. It looks as if we were going to have a very well rounded group of speakers. Many acceptances have already been received.

Respectfully submitted,
GEORGE W. WATERMAN, M.D., *Chairman*

CASH SICKNESS ADVISORY COMMITTEE

During the year your Committee worked with the officers of the Division of Employment Security in the development of a plan under which impartial medical examinations are performed by individual physicians instead of by the staff physicians of the agency. This change was the result of much planning, and a complete report was issued to every physician in the state.

We report that the new program has been most satisfactory. The number of impartial examinations has been drastically reduced, and yet the cost of medical administration has not increased, nor has the benefit total been increased because of the new system.

Every Fellow of the Society was given the opportunity to become an impartial examiner, and the list of those accepting this work was mimeographed by the executive office and supplied to the Division of Employment Security.

We note with interest also that the Agency has provided for the attendance of a physician at all Cash Sickness appeal hearings held by the board of review, a recommendation made by the Society a year ago.

A matter now under consideration is that of establishing some schedule of lengths of periods of disabilities to expedite the processing of claims.

Respectfully submitted,
HERMAN C. PITTS, M.D., *Chairman*

UNIFORM FEE SCHEDULE for GOVERNMENTAL AGENCIES

At the request of the Council a committee consisting of the chairmen of various committees of the Society that are concerned with fee schedules (i.e. Veterans, Vocational Rehabilitation, Cash Sickness, Health Insurance, Tuberculosis, Social Welfare, etc.,) has studied various proposals for a Uniform Fee Schedule for wards and dependents of government.

The Committee recommends to the House of Delegates the adoption of the Michigan schedule, as revised December 1, 1949, with the following fee changes and additions:

Page 2 — Examinations by Specialists

0026	Complete Examination of heart, including electrocardiogram with interpretation	$15.00
	with fluoroscopy	20.00
0026	A Complete general routine examination plus electrocardiogram and interpretation 4 leads	$20.00
	12 leads	25.00
(new)	Complete history and general routine examination	$15.00

0028	Physical examination of heart and lungs including pertinent history	$10.00
0030A	With preliminary K.U.B. film	$40.00
0039	Psychiatric examination (first hour or less)	$15.00

Surgical Assistants

When the nature of an operation is such that the services of an assisting licensed physician are necessary:

When surgical indemnity is:	Assistant's indemnity is:
$50 to $99	$10.00
100 to 150	15.00
over 150	20.00

Respectfully submitted,
HERMAN C. PITTS, M.D., *Chairman*

HEALTH INSURANCE

The Health Insurance Committee has continued to supervise the program of the Rhode Island Plan, meeting with insurance company representatives from time to time to consider problems relating to the program.

With the inauguration of Physicians Service, the committee carefully reviewed the status of the Rhode Island Plan, and upon advice of legal counsel, and others, decided that the program should be continued under approval of the committee as an added incentive for the public to acquire health insurance on a voluntary basis. Our action is duplicated in the state of Wisconsin where both the Society's non-profit program and its plan utilizing insurance carriers is working effectively.

The companies participating in the Rhode Island Plan have been asked to liberalize their contracts insofar as possible, and the master schedule of indemnities has been amended to include medical visits in the hospital, as is permitted under the same schedule used by Physicians Service.

The committee finds that the Society cannot require the insurance companies to write a single standard policy, identical to that offered by Physicians Service, as such action would be tantamount to restriction of trade, forcing all competitors to write a single standard policy. Instead, the companies have been encouraged to make as liberal allowance as possible in their policies under the Plan to aid the people of Rhode Island.

The Committee feels that it should clarify one misunderstanding that may exist regarding insurance company activities in the health and accident field. The Rhode Island Plan operates under a reduced schedule of indemnities, established by the House of Delegates in order to reduce the premium cost of the insurance insofar as possible. This schedule lists fees below the prevailing charges that

continued on next page

physicians in their area may rightfully make. The maximum fee in the schedule is $150, regardless of the operative procedure performed.

However, many industrial concerns, and labor organizations negotiating for employee benefits, seek liberal allowances. As a result the insurance industry has been in a position to offer contracts on a group basis offering a high schedule of indemnities than that offered by the Rhode Island Plan. As a result they have presented such coverage in the best interest of the persons to be insured.

The purpose of this Society in establishing prepaid voluntary insurance was to extend such coverage as widely as possible. We have scaled the schedule of fees to be paid physicians below prevailing charges in order to get the insurance in the hands of persons in lower income groups. However, where persons are above these income groups, or where labor-management negotiations result in the purchase of more substantial coverage, other insurance should be available.

Answers from eight of the thirteen companies in the Rhode Island Plan have so far been received in a recent survey which indicate more than 52,000 persons having surgical insurance. This index of coverage, when augmented by the insurance sold by all other insurance companies would indicate at least 75,000 persons in this state as having surgical-medical insurance.

Your committee feels that the Rhode Island Plan should be continued in the best interests of the public.

Respectfully submitted,

ROCCO ABBATE, M.D., *Chairman*

INDUSTRIAL HEALTH

The bill relating to the medical society's thoughts on changes in the compensation bill was presented to Governor Pastore last year but he found it apparently advisable to pigeonhole the same, and no action was forthcoming.

There have been but few meetings of this committee during the year, however, the committee sponsored a lecture and demonstration by Dr. George G. Deaver of New York on Rehabilitation at the Medical Library on the evening of April 12th. From reports received this would appear to have been worthwhile and successful.

The Chairman of the Committee is also Chairman of a Subcommittee on Physiological Safety, and this report will be forthcoming at the time of the Governor's Conference on Industrial Safety, May 16, 1950.

By authority of the Council of the Society, the Chairman of the Committee attended the annual Industrial Health Congress in New York sponsored by the American Medical Association. The excellent scientific programs, and contacts made at this meeting have been most helpful to the chairman, and through him to the committee.

Respectfully submitted,

STANLEY SPRAGUE, M.D., *Chairman*

LIBRARY

The activities of a Library are measured by the statistics of the work done, and therefore we present the following figures covering the service of our Library to the Fellows and the Community. The last reference is made advisedly, because appeal is constantly being made to the Library for information of all kinds regarding medical matters, and these inquiries come from both medical and lay sources, so that the Library has become in some real sense a Medical Reference Bureau. No account has been kept of the number of requests for advice sought by telephone, but it is safe to say that 20 to 30 calls per day are answered; in many cases this requires consultation of reference books, and other sources.

During the year, there were 2390 visitors to the Library, 379 more than last year. Of these 1365 were physicians, the balance including many students from the various institutions of learning in the city and the surrounding territory. Here again is evidence of the influence of the Library in the community.

Circulation:

Charged out and returned	270	books
	1,435	Journals
At present charged out	58	books
	215	Journals
Total number of items	1,978	
Inter library loan		
loaned to other libraries	49	books
	520	Journals
	569	items

continued on page 379

ANNUAL REPORTS

continued from page 376

Borrowed from other Libraries ..... 3 books
12 Journals

Reference Work:

186 bibliographies prepared, in addition to the large amount of information given by telephone, as already noted.

Periodicals:

We are currently receiving 243 Journals

During the year two new subscription journals were added to the list.

"CIRCULATION"—R. I. Medical Society

"ARCHIVES OF INDUSTRIAL HYGIENE & OCCUPATIONAL MEDICINE"—Providence Medical Association

Binding:

139 volumes of Journals were bound.

Accessions:

Purchase: (21 Day Fund; 4 Davenport Fund; 2 Gormly Fund) Total *27*

From the Rhode Island Medical Journal, sent by the publishers for review. 40

191 books were given to the Library by members, institutions, and friends. The list of donors is long and is evidence of the continued interest of the profession. Two gifts were outstanding; 171 books and periodicals were received from the Library of Dr. N. Darrell Harvey; 283 volumes of Journals from the State Hospital for Mental Disease. In each case, these gifts helped to complete files of certain journals.

78 bound volumes of Journals were added

With the additions of the past year, there are now in the Library about 38,475 books, plus a great number of pamphlets and reprints. Of these 24,430 have been catalogued. Until all these are catalogued it will be impossible to do more than estimate the actual total. As in the Report of last year, we would emphasize the importance of cataloguing; it did not seem feasible to undertake it during the past year, but our Library is a valuable one, and all the books should be available for reference. At present, there are about 14,000 volumes still uncatalogued.

It has been suggested that there be placed in the Reading Room a case in which there could be displayed from time to time rare books, old instruments, and objects of historical interest. This is in line with the practice in many Libraries, and has proven to be of much interest.

During the summer, the Librarian, Mrs. Helen DeJong, was granted a leave of absence for a period of three months, for travel abroad. In the interim, the affairs of the Library were carried on by Miss Dickerman, assisted by Miss Betty Farrell.

Respectfully submitted,

HERBERT G. PARTRIDGE, M.D., *Chairman*

continued on next page

MEDICAL ECONOMICS

In 1948 the Society adopted a resolution requesting that life insurance companies revise upward their fee schedule for physical examinations and reports. This was the second action taken on this matter by a state medical association, New Jersey having preceded us.

To the Committee on Medical Economics fell the task of carrying the negotiations with the insurance companies, and the committee of last year under the chairmanship of Dr. William P. Davis carried on extensive studies and conferences.

Since that time the problem has won nationwide support from medical societies, and the insurance companies have admitted the need for increasing their fees which had remained unchanged for a period of fifty years. The increase has not met the fee proposed by the Rhode Island Medical Society of $10, for most of the companies have settled upon a $7.50 fee for the full medical examination, or for a disability examination.

The new scale adopted by one major life insurance company, which is probably typical of those now adopted by a great many companies, is as follows:

Full medical examination	$ 7.50
Disability examination	7.50
Full medical examination, together with special heart examination	10.00
Special heart examination subsequent to full medical examination	5.00
Junior Medical examination	5.00
Short form examination	4.00
Additional blood pressure and pulse reading	3.00
Additional blood pressure reading	2.00
Additional pulse reading	2.00
Additional home office specimen	1.00

"The fee for an attending physician's statement submitted on our regular form, has also been increased to $3.00."

The latest report from the Bureau of Medical Economic Research of the American Medical Association lists the following insurance companies as having increased their fee schedules:

Aetna Life Insurance
Bankers Life (of Iowa)
Connecticut General
Connecticut Mutual
Continental Assurance
Equitable (of Iowa)
Equitable Life Assurance of N. Y.
Fidelity Mutual
Guardian Life of New York
Home Life
Jefferson Standard
Life Insurance of Virginia
Manhattan Life
Mutual Life
Mutual Trust of Chicago
National Life and Accident
National Life (Vermont)
New York Life
Pacific Mutual
Pan American
Phoenix Mutual
Pilot Life
Security Mutual of Binghamton, N. Y.
Southland Life (Dallas)
Southwestern (Dallas)
Sun Life of Canada
Travelers

Two years ago, in initiating action on the question of fees for examinations for insurance companies, the House of Delegates of our Society adopted the following recommendation:

> That the fee for the initial examination be a minimum of $10, and that fees for subsequent examinations be consistent with the present office fee, but with a minimum of $3; that an E.K.G. and interpretation be $15; and that special examination, such as blood and sugar tolerance tests, be $10.

Your committee now refers this entire question to the House of Delegates for its decision in view of the action that has been taken by the major insurance companies in the intervening time.

Respectfully submitted,

SAMUEL D. CLARKE, M.D., *Chairman*

MEDICAL DEFENSE AND GRIEVANCE

A change in the activities of this committee has been noticed during the past year. Although malpractice suits continue to be brought into the courts, they have often been preceded by a letter to the Society outlining a grievance and with a request for redress or reparation. These communications

continued on page 382

ANNUAL REPORTS

continued from page 380

are investigated and the opinion of the Committee sent in writing to the correspondent.

In many cases nothing more is heard of the matter.

At the present time at least four suits for malpractice are awaiting action in the courts. At the December, 1949, meeting the House of Delegates of the American Medical Association adopted a resolution urging all constituent associations to develop programs whereby patients can present grievances to a proper committee.

We have received requests from at least two state societies asking for information as to the conduct of these hearings.

It would seem advisable that these hearings be held before the entire committee with all sides represented. With such a procedure it may be expected that grievances can often be reconciled and further legal procedures avoided. The committee again wishes to emphasize the importance of reporting promptly any case where a patient seems likely, by his attitude, to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment administered, even if the case has not been referred to a lawyer.

Respectfully submitted,
ROLAND HAMMOND, M.D., *Chairman*

PHYSICIANS SERVICE

Subsequent to the January meeting of the House of Delegates at which the medical members of the board of directors of the Rhode Island Medical Society Physicians Service were elected, a meeting was held and six lay representatives were selected. These laymen who are serving as members of the board of directors this year are:

Mr. Thomas C. Dignan, President of the Narragansett Electric Company
Mr. Emil E. Fachon, Vice President of the Bulova Watch Company, Inc.
Mr. Walter F. Farrell, President of the Union Trust Company
Mr. Felix A. Mirando, Secretary-Treasurer of the Imperial Knife Company
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Mr. John Shepard II, of The Shepard Company

The entire board of directors has met and has formulated policies and programs for the effective operation of Physicians Service. The board has established an executive committee, a finance committee, a professional advisory committee, and a joint operations committee.

Close cooperation has been given the Blue Cross officials in their task of merchandising the Physicians Service contracts. The Joint Operations Committee has given freely of its time and energies, meeting often, to clarify the many problems that are bound to arise in the furtherance of the program. We are appreciative of the enthusiastic efforts of Mr. Stanley Saunders, executive director of Physicians Service, and his staff, for their excellent promotion work in the first five months of the plan's operation.

By the end of this month Physicians Service anticipates a total enrollment of close to 50,000 subscribers, approximately one seventh of the eligible population, thus making our Plan the fastest growing one in the nation.

We are pleased to report that the Fellows of the Society have responded excellently to our appeal that they serve as participating physicians. At this time we have 638 physicians so enrolled.

The coming months promise to bring us new challenges as we cope with the problems incidental to the expansion of Physicians Service. We ask that every Fellow of the Society cooperate fully with our program, and that they communicate promptly to the executive office of the Society for information on any phase of it upon which clarification is required.

Respectfully submitted,
JOSEPH C. O'CONNELL, M.D., *President*

PUBLICATION

The Rhode Island Medical Journal, official publication of the Society, continues to bring credit upon the medical profession of this State by the excellence of the articles that have appeared in it during the past year. Many requests have been received for reprints of various scientific papers we have published.

Through its editorial comment the Journal has endeavored to present the views of the Society and many of the editorials stimulated favorable comment in the daily press. The editorial staff has done a commendable job during the year, and credit is due especially to Doctor Peter Chase who has dis-

charged the dual offices of Editor-in-Chief of the Journal and President of the Society.

The advertising revenue is not as ample as it was during and immediately after the war period. However, the Journal receives excellent consideration from advertising agencies, and the business management is competently handled through the executive office. The members of the Society undoubtedly have but a limited knowledge of the tremendous amout of work that goes into the complete production of our monthly publication, including the bookkeeping and billing of some fifty advertising accounts each month. The committee on publication desires to express its sincere appreciation of the efficient and loyal work of our Editor-in-Chief and of our Executive Secretary to whose efforts much of the success of the Journal is due.

The Journal completed the fiscal year with a cash balance sufficient to meet its current operation, and thus it continues to operate efficiently without any appropriation from the Society.

The Committee urges the Fellows of the Society to prepare and to submit scientific papers for publication in the Journal during the coming months.

Respectfully submitted,
JOHN E. DONLEY, M.D., *Chairman*

PUBLIC LAWS

All legislation proposed to the General Assembly is checked by the executive officer of the Society to determine how such measures would affect public health or medical care in the State. Particular proposals are then submitted to the Committee on Public Laws, which, with advice of legal counsel, has prepared opinions of the various measures, and has made known the views of the Society on them to the proper committees of the General Assembly and to the Governor.

In the session recently concluded several proposals were strongly opposed by the committee. Of particular note was a proposed act that would weaken the basic science law and thereby the licensure standards of the State for those who would practice the healing art. This measure was not referred out of the Assembly committee.

A protest was made against a measure that would have allowed a statement of fact or opinion on the subject of science or art contained in a published treatise, periodical, book or pamphlet, in the discretion of the court, to be admissible in actions of contract or tort for malpractice. A lengthy statement of objections was submitted to the Assembly committee regarding this proposed act, and the measure was subsequently not reported out to the legislature.

Objection was also voiced to a proposal for a comprehensive state wide compulsory health insurance system on the grounds that the Physicians Service, Blue Cross, and the insurance industry were providing adequate insurance on a voluntary basis, and there is no need for a compulsory tax system to be considered in Rhode Island.

Among the measures enacted by the Assembly, and subsequently signed by the Governor, of public health interest, were the following:

An act providing for the administration of first aid and/or other medical services in places of employment. Under this act firms employing less than 400 must employ one or more persons qualified as first aid workers, and those employing more than 400 must set aside and equip a special accident room. Standing orders for nurses are to established in accordance with those published by the American Medical Association in 1943.

* * *

An act amending the general laws relating to jury duty, and providing that on written claim therefore physicians and surgeons (among others) would be exempt from serving as jurors. The Society made known its stand on this legislation early in the session. (See R. I. Medical Journal, February issue, 1950, page 80)

* * *

An act amending the Medical Examiners statute enacted in 1949. The amendments raise the salary of the chief medical examiner to $9,000 annually, plus travel expense, allow for vacation and sick leave, drop the requirement that he would have to be a pathologist, provide for the engaging of an assistant medical examiner, and specify duties of county examiners.

A sub committee of the Council of the Society made recommendations to the Governor and to the Attorney General regarding amendments to the 1949 statute, but the solution offered by this committee was not accepted.

The Committee on Public Laws took no action on this amended act in view of the fact that the Society had already made known its views, both this year

continued on next page

through the special Council committee, and a year ago through the joint committee of the Society and the Bar Association.

* * *

An act appropriating for the fiscal year ending June 30, 1950, the sum of $329,300 to Rhode Island Hospital, $70,800 to Newport Hospital, and $6,400 to Woonsocket Hospital for "partial reimbursement for service to public ward patients for acute medical or surgical conditions, or maternity care." These appropriations were made in accordance with the statute enacted in 1948 in which it was resolved that voluntary general hospitals are eligible to appeal for state assistance for the purpose as noted above.

* * *

Amendments to the state workmen's compensation act passed by the Assembly included one providing that "neither the employee nor his dependents shall be entitled to compensation for disability for death resulting from such occupational disease, unless such occupational disease is due to the nature of his employment and was contracted therein. The time limit for bringing suit under this section shall be 24 months from the date of disablement, and the date of contraction of the disease shall not be a limiting factor."

Another amendment permits the per diem payment for hospital stay to be raised to $10 as a maximum.

* * *

An act providing for the establishment of a committee on children and youth and preparation for participation by Rhode Island in the 1950 White House Conference.

* * *

A resolution granting an extension of time to the special commission to investigate the advisability of establishing facilities in this state for the study, treatment and care of inebriates.

* * *

A resolution upon the death of Dr. John F. Kenney, former President of the Rhode Island Medical Society.

Respectfully submitted,

ALBERT H. JACKVONY, M.D., *Chairman*

PUBLIC POLICY AND RELATIONS

The Committee met frequently throughout the year and all sessions were well attended. Many problems were presented and all aspects thoroughly explored. A detailed description of our activities would require a voluminous and time consuming report that I will therefore merely list the activities of the committee, and I am prepared to discuss in detail any phase on which a delegate desires more specific information.

The committee began the year with a dinner at the Hope Club for the district society presidents and secretaries. We had 100 per cent representation. At this meeting the district society officers were urged to develop their own public relations programs with special emphasis on the problems of night and emergency call service—elimination of any local points of friction—the establishment of contacts with civic groups and editors of local papers. Each person present was presented with literature and a booklet entitled "Public Relations for County Medical Societies."

Following this meeting a representative of the committee visited in turn each of the district medical societies of the State and brought the message of public relations to the entire membership.

Your committee took cognizance of the press reports relating to the release of bookies and petty criminals from jail on the recommendation of physicians. Every case was investigated—the findings reported to the Council—and recommendations made to prevent repetition of the incident.

We also investigated all "letters to the editor" and news reports critical of the medical profession. In each case the facts were evaluated and the situation analyzed and remedies proposed.

Further committee activities were as follows:

1. We analyzed Senate bill 1456 and released a summary of this act to the members of the Society.
2. Interviewed editors and corrected misrepresentations and distortions appearing in Editorial columns. In every case better press relations resulted.
3. We made detailed analysis of critical editorials and corrected the material for the benefit of the editor.
4. Replied to Attorney General McGrath's charges of AMA dictatorship in the press.
5. Evoked favorable editorial comment in two weekly newspapers regarding the Whitaker Baxter campaign against socialized medicine.
6. Supplied weekly newspapers with cartoon material on socialized medicine. This material was used in three instances by the weekly papers.
7. Arranged for the appearance of Dr. Marjorie Shearon in Providence as a speaker for the meeting of the Woman's Auxiliary.
8. Arranged for two general meetings of the memberships of the Rhode Island Medical Society and the Woman's Auxiliary as indoctrination courses to acquaint the membership of both organizations with the subject of Socialized Medicine. At one of these meetings Dr. Dunlop, formerly a British physician, spoke on Socialized Medicine in England.
9. At the request of the AMA your chairman presented a paper at the Annual Public Relations Conference held at AMA headquarters in Chicago. A summary of this paper appeared in the December issue of the Rhode Island Medical Journal.
10. Your chairman was also invited by the AMA to go to Chicago and Washington and participate in the opposition to HR 6000.
11. Members of the Committee have appeared as speakers before six service clubs, four employee organizations, three colleges, two schools of nursing as well as a radio broadcast and a dental society public information program.
12. All members of the committee have been completely informed of all AMA activities and the actions of Congress through news releases from the Washington office of the AMA and from the Secretary's office in Chicago.
13. Public relations material from other states and AMA headquarters have been reviewed by the committee and used to shape the course of our own activities.

continued on next page

14. The Woman's Auxiliary have as a representative on our Committee, Mrs. George Bowles, who has been most cooperative.

15. Mrs. William N. Hughes, President of the Woman's Auxiliary, has been of much help in participating in the planning of our Speakers Bureau. We are also grateful to Mrs. Edward V. Famiglietti, Mrs. Arthur Hardy, Mrs. Joseph C. Johnston, Mrs. Arnold Porter, Mrs. Fred Webster, as well as Dr. Freeman Agnelli, Dr. Donald DeNyse, Dr. Osmond Grimes, Dr. Charles Millard, Dr. Orland Smith, for attending the series of lectures of socialized medicine.

    The committee provided text books—pamphlets, lecture notes and reference material on the medical, economic, and social aspects of health in the United States in an effort to develop a nucleus for a speakers bureau. During the course we utilized lantern slides, charts and our tape recorder. We believe, that as a result, we have an excellent speakers bureau fully informed and technically trained to espouse the cause of medicine under any circumstances.

    We are particularly proud of this accomplishment.

16. Your chairman has written and your committee has published a treatise on "Health Insurance—Voluntary vs. Compulsory" for use by physicians as well as students in schools and colleges who may be desirous of information on the subject in a simple and readily understandable form.

17. A package library in a folder describing the medical library has been prepared for distribution to libraries, schools, colleges and other interested parties.

18. Upon the advent of John T. Flynn's book "The Road Ahead" your committee made copies available to the Library, and sent illustrated advertising postcards to all members of the Medical Society calling attention to this book and urging its purchase and distribution.

19. Through the news clip service we have been completely informed of all press releases regarding medical care and doctors. We are happy to report less criticism and much more favorable press at this time.

20. By authority of the Council we published RIMSCOPE, one issue of which has already been sent you. Other issues will follow at irregular intervals. The purpose of this public relations bulletin is to call your immediate attention to special conditions and important events affecting your welfare. We hope it will command instant attention, and study when you receive it as it will stress VITAL news not ordinarily found in the Medical Journal.

21. The problem of adding a public relations director to the executive staff has been given a great deal of time and attention by the committee. A local organization prepared and described a program for us, several interviews were held with the director and the committee found that the cost of an all out public relations program was prohibitive. The employment of an additional member of the staff would be feasible only as an assistant to the executive secretary, Mr. John E. Farrell. If the proper person can be obtained at a price within what we are willing to pay we recommend that such an addition to the executive staff be made. We also recommend that Mr. John Farrell direct all staff activities and delegate to the assistant such problems and duties as he may from time to time desire to undertake.

    We further recommend that the House authorize a press relations conference whereby the committee would invite editors and managers of daily and weekly newspapers in the state to participate in a panel discussion or open forum for an entire day. This session to be held at the Medical Library with a buffet lunch at noon and dinner at one of the clubs in the city that night. The purpose of this would be to exchange views and to arrive at a more mutual understanding.

    We recommend that the House take cognizance of the need for night and emergency service and that it go on record as affirming the principle that the health and welfare of the people is the direct responsibility of the whole medical profession. We suggest that the House direct to the district medical soci-

eties to concentrate every effort in providing the solution to this problem in each locality in the state.

We propose for the next year a campaign to acquaint the Rhode Island public with the facilities available for medical care in this state and to inform them as to how to use such facilities to the greatest advantage.

Respectfully submitted,

CHARLES L. FARRELL, M.D., *Chairman*

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BOOK REVIEW

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS by Paul Haun, M.D., Med. Sc.D., Assistant Professor of Psychiatry, Georgetown University Medical School. Architectural Record division of the F. W. Dodge Corp., N. Y., 1950. $4.00.

The desirability and many advantages of a complete psychiatric unit in a general hospital are clearly set forth in the first section of this book. It would be difficult for any practicing physician or thoughtful layman to disagree with the reasons given for the necessity of the proposed facilities.

In working out this type of unit, the use of an architect to assist the planning board is stressed as it is felt this department should not be haphazardly added but should be carefully integrated with the hospital as a whole. There are many plans given in detail to choose from with a preference as to location given to the top floor of the hospital building.

There are certain practical problems involved which could be discussed more freely with added interest to the reader, for example, the length of stay (short for study and diagnosis, long for treatment and rehabilitation) and the assurance that other hospital patients would not be disturbed or endangered by psychiatric patients in the same building. The use of a separate building attached to the main hospital by a tunnel was not discussed.

On the whole, I feel this book contributes a great deal in bringing out the need for better psychiatric care in most communities and the great advantage of having a psychiatric unit in a general hospital accessible to all.

HILARY J. CONNOR, M.D.

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TABLE OF CONTENTS